UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

NEXAVAR (sorafenib)

Patient name:_____Medicaid or SS#_____

Physician Name:_____Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Patient must be age 18 or above
- Diagnosis of advanced Renal Cell Carcinoma

Authorized:

400mg BID until no benefit or side effects are unacceptable

Re-Authorization:

Re-auth for 1 year accomplished by a phone call from the doctors office or the pharmacy

Information:

Nexavar is available only through 5 specialty pharmacies via mail-order: Caremark, Curascript, Accredo (Medco), Pharmacare, McKesson Specialty

7/19/6